Dr. H. C. McClenahan: First, I wish to subscribe generally to what Dr. Richards has said. It seems to me, however, that the question to be decided by this society is not whether we could get psychiatric wards in the County Hospital, which I agree with Drs. Moffitt and Wilbur is a makeshift, but to make recommendations, looking forward to a correct solution to the handling of the insane in large cities. I do not think we can make any mistake if we profit by the experience of other large municipalities, such as Philadelphia, Boston, and New York, in their attempts to solve this problem.

They found the psycopathic clinics, and the psycopathic wards in the general hospitals, inadequate, and have established state psycopathic hospitals in those cities, at least so in Philadelphia and Boston (I am not well acquainted with the situation in New York but had occasion to observe the work at Blockly Hospital). As you all know, while this is a general hospital, their psycopathic department is practicaly a separate institution in grounds to itself. Cases are sent from all the different clinics. The commitments are done in the hospital; if necessary delayed, and the hospital has a regular staff from the different teaching institutions.

In Boston they have been wrestling with this question for the past fifteen years, and finally established a state psycopathic hospital, only last year. Dr. E. E. Southard is its medical director, and also occupies the chair of neuropathology at the Harvard Medical School. A very interesting historical review by Dr. Channing of the establishment of this hospital is to be found in last November's Journal Nervous and Mental Diseases. I think you will find that under the California constitution, the insane are regarded as wards of the state and not the municipality. Hence to recommend the municipality's taking primary steps would seem to be going at the problem from the wrong end.

Instead of Dr. Wilbur's resolution, I should have very much preferred that this society go on record as in favor of the establishment in San Francisco of a state psycopathic hospital, with the co-operation of the municipality, and the privilege of availing itself of the teaching staffs of the two universities; this hospital to be distinct from the county or any other hospital. If we are unable to secure such a hospital at the present time, then the establishing of psychiatric wards in the County Hospital might be justified especially to fulfill the purpose of study and teaching. (Dr. Wilbur changed his motion to read "the establishment by the state of a central station for acute mental cases in San Francisco," etc.)

We must not forget that in the establishment of State hospitals their location in the county was largely due to the position of the medical profession, i. e., that about all that could be done for the insane was custodial care, where they could get fresh air and work on the farms, etc. We know that this applies only to a part of the mentally affected and that particularly acute cases of mental disorders are sick people and require correct diagnosis and the best hospital facilities possible. And since medical men have created this attitude on the part of the legislative bodies, I think it is up to us to correct that impression, and put the lawmaking bodies right as to the present status of scientific medicine toward mental disorders.

I do not agree with Dr. Brown that the alcoholic can be best treated in psycopathic wards, or anywhere else, unless he is primarily controlled, and I mean by control, legal control, without which practically all efforts at successful treatment are futile. The alcoholic who requires treatment requires control first. This is in accord with the large majority of those who have had extensive experience with these individuals.

Dr. H. C. Moffitt: I agree with Dr. McClenahan, and I would not care to go on record as favoring this proposition except as a makeshift, aiming eventually at an institution which is big enough, one modeled after the successful one lately opened in Boston. As I understand it, the committee is to confer with Dr. Hatch and prepare a proper scheme, of which this is a part.

Dr. Richards (closing discussion): This question of psychiatric hospitals or wards and of after care of the insane has become very active in many places in California. In Los Angeles they have already established psychiatric wards and an after-care society. As to the state establishing a psychiatric hospital in San Francisco, it would probably be advantageous to consider the question of the state's present obligations. One-third of the people of California live south of the Tehachapi Pass, and in that section there is only one state hospital. It is evident that the state must meet the need of an additional state hospital in that section. At present, in several of the state hospitals, the number of patients is in excess of the capacity of the hospitals, and the patients are sleeping in corridors and on the floors. At this time, therefore, the state has all that it can well do in regard to the establishing of hospitals. The question is not that we are doing the ideal thing in arranging for psychiatric wards instead of a psychiatric hospital, but that we are doing something. From the discussion here to-night I think it is perfectly well-established that co-operation is the thing that is chiefly needed. I believe that the committee to be appointed,—after consulting with Dr. Hatch,—will be able to report to the society the best measures possible. The work is practically one that follows from the beginning of mental disease in the locality in which it originated to the state hospitals. I wish distinctly to insist that state hospitals are not homes for incurables; but that in each of our state hospitals is a receiving department, where all possible measures are taken to effect speedy cures. We have a percentage of recoveries that is entirely satisfactory. But there is a wide field in the first care of mental cases,—the responsibility of which rests with the cities. In addition, it is true that the physicians in the state hospitals should have opportunity for post-graduate work in their particular lines in the medical centers of the state. I think that to-night we have seen a movement begun that will result, not only in the ultimate establishment of a psychiatric hospital, but in a national society for mental hygiene; that the work will begin in the medical society and be under the direction of medical men; and have an entirely harmonious development of the treatment of psychiatric diseases in the large cities. This is something for which we should be very grateful.

RAILWAY SURGEONS

REPORT OF A CASE OF SARCOMATOSIS.*

By J. H. O'CONNOR, M. D., and W. T. CUMMINS, M. D., San Francisco.

History: Mr. C. H., aged 49, an engineman, was admitted to the Southern Pacific General Hospital on September 23, 1911. His father and mother died of pneumonia. Patient stated that his habits were temperate, and that he had had gonorrhea but denied luetic infection. No other diseases were elicited. Present condition began three years before with a slight swelling in the left supraclavicu-

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lar region. This gradually increased in size without pain or loss of weight.

Examination: Patient appeared well nourished. Pulse and respiration normal. No fever. Tongue clean. Thorax and abdomen negative. In the left supraclavicular region there was a firm, movable mass about the size of a hen's egg. Other superficial lymph nodes not palpable.

Urinalysis: September 23, clear, yellow, sp. gr. 1020. Acid. No albumin nor sugar. Uratic sediment.

On September 25 the supraclavicular nodule was removed under ether anesthesia. Cyanosis and dyspnea rendered oxygen necessary. Pathologist's report notes "that the tumor was the size of a small hen's egg, of soft consistency and having a thick fibrous capsule. The cut surface was white with numerous yellowish, soft areas. Sections show tumor to be made up of bands of connective tissue between which are areas of large cells with rather clear, oval nuclei arranged between delicate fibrils of connective tissue. Many of these areas show fatty degeneration of the cells and in the centres considerable necrosis."

Diagnosis: "Sarcoma" (Dr. H. W. Gibbons).

The patient remained in the hospital 43 days, having been discharged apparently well on November 6. Except for a period of 5 days beginning the day after the operation the pulse, temperature and respirations were normal. The maximum during this period was 100.6° On October 10, ½ minim of Coley's fluid was inoculated and this was repeated on October 13, 20, 23, 26, 30 and November 1. The only reaction in each instance was profuse perspiration.

He was readmitted to the hospital on May 23 with the following history in the interval: Evidences of tumor growth appeared at the site of operation one month after discharge from hospital. About the middle of February a small, superficial mass appeared in the right, lower, abdominal quadrant and this slowly increased in size. Just below the right clavicle a mass similar in character appeared about May 1. There were no subjective signs; the tumors were painless.

Examination: Large, stout, well-built man. Eyes, nose, ears and mouth apparently normal. Lungs negative but heart sounds were rather weak. A freely movable superficial nodule 1x2 cm. (lima-bean sized) was seen in the right infraclavicular region. Another nodule of about the same size was seen in the anterior abdominal wall, as above noted, and this was firmly adherent to the underlying tissues. Other smaller nodules were seen just to the right of the xiphoid cartilage, around the umbilicus, and over the biceps of the right arm. Reflexes were normal. There were no evidences of intracranial disease. The thyroid was apparently normal.

Urinalysis: May 24, clear, yellow, sp. gr. 1022. Acid. No albumin nor sugar. Microscopically negative.

On May 25 he was again operated upon and the tumor on the arm and those near the xiphoid and right clavicle were removed by wide incisions. There were no post-anesthetic complications. The tumors were of fleshy consistency, coarsely granular, and contained a moderate amount of blood. Several small areas of softening were seen, the consistency being that of thick cream. Microscopic examination showed each nodule to be made up largely of definitely circumscribed collections of cells with oval and round vesicular nuclei enclosing in many places vascular clefts. Many of these cells appeared spindle-shaped. Occasional karyokinetic figures could be seen. Some sections showed extensive necrosis. Here and there collections of lymphoid cells were noted.

On May 30 restlessness developed and on June 1 severe headache and nausea appeared. The following notes were made on June 8: "For the past few days the patient seems to have lost power of using the left arm. He has had severe frontal headache and seems drowsy much of the time. He appears uncomfortable in bed and frequently changes his posture. No aphasia. Slight paresis of left side of face. Temperature and tactile sense equal on both sides. Left arm shows marked weakness. All motions are performed slowly and with apparent effort of the will. Temperature and tactile sense present. Temperature sense is lost in left hand. He fails to localize tactile sensations in the fingers. Left leg is unaffected. Reflexes active. No Babinski, etc. Muscular power good." (Interne, Dr. Powers). Evidences of recurrence of mass near xiphoid were noted and the smaller nodules near the umbilicus rapidly increased in size.

On June 9 the patient became delirious for a short period of time and upon recovery from the same complained of severe headache. Restlessness was a prominent symptom. Dysphagia was noted on the 13th and on the following day there was a short period of coma. Weakness increased, the periods of coma became more frequent, Cheyne-Stokes' breathing developed and death occurred on June 16.

Clinical Diagnosis: Multiple sarcomata (sarcomatosis).

Postmortem Record: Moderately obese adult. Marked rigidity of extremities and moderate lividity of dependent parts. No eruption, scars, bruises, nor bed sores. Incisions from recent operation in epigastrium, over right clavicle and right upper arm. Eyes, ears, nose and mouth apparently normal. External genitalia normal. Superficial lymph nodes not enlarged.

Preliminary abdominal incision showed much adipose tissue. Peritoneal serosa smooth, moist and pale with normal amount of clear, yellow fluid in sac. Omentum contained much fat and extended to a point midway between the umbilicus and pubis. In the omental tissues (median line) and overlying the transverse colon a nodule was noted of flesh-like consistency and color and of horse-chestnut size (3x2x1 cm.). Overlying this and situated in the muscular tissues of the abdominal wall close to the preliminary incision and just above the umbilicus there was a nodule identical in general appearance wth the preceding but somewhat larger (5x5x3 cm.). Another nodule of intermediate size (5x3x1 cm.) was intramuscularly located just below the tip of the xiphoid cartilage. In the left iliac fossa near the attachment of the descending colon two lima-bean sized, chalky-white, pedunculated, fleshy, peritoneal nodules were observed. Further peritoneal examination revealed four soup-bean sized masses in the mesentery of the small intestine, the same in the left perirenal adipose tissue, one chestnut-sized nodule at the head of the gall bladder and the same between the bladder and the rectum. Position of organs normal. Diaphragm on left side at 5th rib and on right at 4th rib.

Spleen weighed 180 grams—12x7x2 cm. Color was gray and consistency rather soft. Capsule wrinkled and stripped with difficulty. Cut surface brownish red, pulp soft and trabeculae very prominent, while follicles were indistinct. No evidence of tumor metastasis. Liver weighed 1680 grams—22x15x6 cm. Color was pale, yellowish red and consistency rather soft. Capsule smooth but presented several pinkish white, slightly elevated, split-pea sized (5x10 mm.) areas the counterpart of which were found upon incising the organ. They were definitely circumscribed but were evidently not encapsulated. The intervening parenchyma was yellowish red. There were no signs of cirrhosis. Gall bladder was distended with dark green fluid. No calculi. Mucous membrane and wall apparently normal except at head where there was a soft, dark green nodule of chestnut-size projecting into the cavity. The ducts were patulous. The stomach wall was of normal thickness. Mucous membrane congested and focally hemorrhagic. The intestinal

mucosa was moderatelv congested throughout, while here and there small hemorrhagic points were seen. Mucosa of the colon was somewhat thickened and in the cecum and ascending colon follicular changes were observed. Appendix was 11 cm. long and showed moderate congestion of mucosa. Split-pea-sized concretion present at tip.

Pancreas weighed 270 grams—17x5x3 cm. Uniform induration of moderate grade was noted except for several small nodules of firmer consistency. General color was pinkish white.

Left kidney weighed 260 grams—10.5x6.5x4 cm. Considerable difficulty was experienced in removing the organ on account of the dense adhesions to the surrounding tissues. Dark red and flabby. Capsule stripped with difficulty. Incision showed moderate amount of blood. Color brownish red. Cortex moderately increased (10 mm.). Several pea-sized, pale, firm nodules were scattered through the cortex and medulla. Pelvis was apparently normal. Ureter and adrenal apparently normal. Right kidney weighed 190 grams—11x6x3.5 cm. It was similar in general appearance to its fellow except that only one nodule of pea-size was seen. Ureter and adrenal apparently normal. Bladder showed moderate diverticulation and thickening of wall. Prostate was about the size of a horse-chestnut but showed no evidence of metastasis, although there was a contiguous nodule, as before described. Rectal wall also was not involved. Testicles were apparently normal, while the left epididymis showed some nodular thickening.

Left pleural sac showed no excess of fluid and no adhesions. Lung weighed 610 grams—20x17x6 cm. Color was slatey gray with anthracosis. Surface showed a few small, pale, somewhat elevated, firm nodules. Upon incising these resembled those of the liver. Further incisions showed more nodules between which the tissues were uniformly crepitant and anthracotic except at the base of the lower lobe where some congestion and edema were seen. Right plural sac showed no excess of fluid and no adhesions. Lung weighed 910 grams—21x17x5 cm. Same general color as its fellow. Above mentioned nodules were less numerous but larger than in the left lung. They varied from the size of a millet seed to that of a horse-chestnut but of the same general color and consistency. Congestion and edema at the base of the lower lobe.

Pericardial sac showed a moderate increase of clear, yellow fluid. No adhesions. Heart weighed 380 grams—14x9x5 cm. Moderate amount of subpericardial fat. Coronary vessels apparently normal. Muscle dark red and somewhat flabby. Valves apparently normal. In the right lateral wall of the right auricle there was a fungoid, chestnut-sized mass 2x1.5 cm. projecting 0.75 cm. into the chamber, of pinkish color, firm consistency and with nodular surface. This extended to the subpericardial tissues. In the posterior wall reflected through the endocardium there was a split-pea-sized, yellowish, slightly elevated nodule. In one of the tricuspid papillary muscles near its distal end there was a millet-seed-sized, yellowish nodule embedded in the tissues. Aorta showed in its arch numerous large and small yellow plaques of sclerosis.

The thyroid gland was moderately enlarged, firm and somewhat paler than normal. Incising showed almost its entire substance to be yellowish white and in places cheesy, while there was no clear demarcation between this and the apparently normal tissues. Deep cervical lymph nodes were pea-sized and incisions showed uniformity of structure—pale and firm.

Brain: Weight 1290 grams—21x17x8 cm. Convolutions well formed. Meningeal vessels moderately congested. No exudate nor fibrous thickening. Distant 1.5 cm. from the longitudinal fissure in the right parietal lobe there was a gray, non-elevated, soft, definitely circumscribed area about the size of a quarter dollar—2x2 cm. Meningeal surfaces elsewhere were negative. Upon incising the right hemisphere this mass was found to extend well into the temporo-sphenoidal lobe with its axis at right angles to the longitudinal fissure and throughout its entirety without cortical invasion. It was materially softer than the surrounding tissues and clearly demarcated therefrom; gray in color; with points of hemorrhage—6.5x5.5x3 cm., the latter being the depth of the mass. Upon incising the left hemisphere just below the cortex there was found almost directly opposite the above and equidistant from the longitudinal fissure, an area similar in color, consistency and demarcation and of pea-size. Close to this was an area of hemorrhage. The cerebral tissues in both hemispheres were uniformly pale and soft. The cerebellum was apparently normal. The pons showed punctate hemorrhages. (The spinal cord was not removed.)

Histologic Examination: Brain: Sections of the right parietal lobe showed a clear demarcation of the tumor from the surrounding normal tissues. In places the intervening zone showed hemorrhage. Where the tumor appeared upon the serous surface of the organ there were no remains of meninges but in adjacent areas there was no evidence to show that the tumor had a meningeal origin. The cells composing the mass were multiform, i. e., stellate, spindle-shaped, oval, round and other bizarre shapes—all with round or oval vesicular nuclei which here and there showed karyokinetic figures. These cells were for the most part arranged in irregular masses—wide and narrow bands and circular masses. There were several blood vascular channels (filled with erythrocytes) which were completely enclosed by these cell masses, while in addition there were a few similarly enclosed clefts, the vascularity of which was indefinite. Congestion was moderate, a few hemorrhagic areas were seen. A number of necrotic areas were scattered through the tumor. Sections of the left parietal lobe through the previously mentioned pea-sized nodule showed it to be made up of tissue identical in appearance with that immediately described. Sections of the apparent hemorrhagic area showed it to be another tumor nodule—a counterpart of the preceding ones—with considerable necrotic and hemorrhagic changes. Thyroid: Sections through the isthmus showed necrosis as a feature. Elsewhere, cellular masses were seen in conformation similar to the preceding. No stellate cells were to be seen. Vascular channels were few. The thyroid tissue itself showed atrophic acini and very small amounts of colloid.

Heart: Sections through the fungoid, auricular mass showed closely massed cells of the forms noted in the thyroid. Vascular clefts were few. Several hemorrhagic and necrotic areas were present. Sections through the smaller auricular nodule revealed a similar structure while from those through the involved papillary muscle no satisfactory examination could be made. Lung: Sections through a medium-sized tumor nodule showed the cells and conformation of masses similiar to the thyroid. Scattered collections of lymphoid cells were evident, as well as a few necrotic areas. The adjacent pulmonary tissues were moderately congested, fibrous and anthracotic. Spleen: There was moderate capsular and trabecular fibrosis, as well as congestion. The small follicular arteries showed hyalinization of their walls. There was absence of tumor metastasis. Gall Bladder: Sections of nodule showed structure similar to thyroid. Pancreas: Sections through grossly described nodules showed indefinitely outlined tumor masses closely resembling that of the thyroid. Moderate congestion and several necrotic areas were noted. Elsewhere the tissues were fibrotic. Small Intestine: There was moderate fibrosis and round cell infiltration of the mucosa and submucosa. Kidneys: Moderate cloudy swelling of the cortical epithelium

and moderate hyperemia were evident. Tumor masses were indefinitely outlined but identical in structure with the thyroid. Several hemorrhagic areas were included and at the margins of the nodules collections of round cells were seen. Prostate: Many acini contained corpora amylacea. Some hyperplasia of the connective tissue noted. No tumor metastasis. Testicle: Moderate degree of fibrosis present. Peritoneal, retroperitoneal, mesenteric, omental and retrovesical nodules showed tumors identical in type with that of thyroid. The same may be said of the intramuscular growths in the anterior abdominal wall. Deep cervical lymph nodes showed lymphoid hyperplasia but no metastasis.

Pathologic Diagnosis: Endotheliomata of the thyroid, cerebrum, heart, lungs, liver, gall bladder, pancreas, kidneys, peritoneum and anterior abdominal wall; chronic interstitial pneumonitis; splenitis; pancreatitis; enteritis and appendicitis; acute parenchymatous nephritis; chronic prostatitis and orchitis; lymphoid hyperplasia of deep cervical lymph nodes.

Remarks: The following points in this case are of interest: the multiple peripheral foci, the extensive internal metastasis, the almost complete involvement of the thyroid without evidences of hypo- or hyperthyroidism, and the widespread destruction of the right parietal lobe with the first appearance of cerebral symptoms only two weeks before death. All the tumors had uniformly the same structure, except that there were numerous stellate cells in the cerebral masses and an absence of the same elsewhere. With the vascular channels, the forms and arrangement of the cells, endothelioma was suggested; however, there seemed a possibility that the cerebral condition might be gliosarcomatous. Mallory's and Van Gieson's stains excluded the latter. It is likely that the primary focus was situated in the thyroid on account of the almost complete involvement and widespread necrosis of the same with the presence of a single mass and that the brain was secondarily invaded as indicated by the multiple masses.

A FEW REMARKS ON THE MANAGEMENT OF TYPHOID.*

By G. R. CARSON, M. D., San Francisco.

About fifty or sixty typhoid patients of all types enter the Southern Pacific Hospital every year; walking typhoid, para-typhoid and severe hemorrhagic types. Some of these cases arrive in the first week, others in the second and third weeks. Some are transported from quite a distance; so we have a fairly good opportunity for observing and studying this disease. I have observed some five hundred cases during the past few years, from the days of the strictly milk diet and ice cold baths to the days of forced feeding and the tepid sponge. Naturally some of these observations have left rather marked impressions on me.

It is not necessary to give a typhoid drugs just because he has the disease; the less drugs the better the case will do. There is far too much unscientific prescribing. It is a mistake, and one that is very prevalent to believe that therapeutics means treatment only. Therapeutics covers the whole field of management of the disease. It is a mistake for a physician to declare he has cured typhoid; what he does do is to manage the disease and the patient who has it. The details of this management, diet, physical treatment, and lastly medical necessities, comprise the therapy of the fever. In other words, more therapeutics and less medicines in typhoid.

Why should we not feed our typhoids when Nature calls out so for assistance? Are we to remain blind to this call? If he is hungry, feed him—a moist tongue and an appetite is a good guide. The mortality is lessened by feeding. Years ago at the Southern Pacific Hospital our mortality was about 12 per cent.; it is now about 2 to 3 per cent., and some years no per cent.

It is a mistake to begin with a milk diet and later during the height of the fever commence feeding your case. Start with a good varied diet from the onset. A liberal diet of high caloric value is indicated to keep up the body weight. Dr. Warren Coleman of Cornell, whose recent articles have appeared in the medical journals, has done much work along this line. In fact one of his recent associates informed me that he gave a prize to the typhoid who ate the most. The well-fed typhoid goes through the disease happier and more contented. Tympanites and other complications are lessened and we really have not any sequela with which to deal. The convalescent stage is virtually eradicated. It is doubtful if it ever will be determined that any one diet is the only correct one for typhoid fever—the patient has his dietary habits and his ability to digest certain foods during typhoid fever must be individualized. Therefore a diet correct for one patient may be absolutely incorrect for another.

Also such complications as diarrhea, hemorrhage and vomiting must be considered. It is often necessary to stop all feeding for a time. The diet now in use at the Southern Pacific Hospital is varied and mixed and consists largely of eggs, milk, oatmeal gruel, tea, coffee, cocoa, rice, wine and orange jelly, various soups, crackers with milk, soft puddings, ice cream, soft toast, apple sauce, buttermilk, finely minced lean meat, soft part of raw oysters and many other articles of food. Salt and sugar are used enough to flavor. The food is given in small quantities every two hours during the day and every four hours during the night if patient is awake, but must not be disturbed, as sleep is very essential. The object in mind being to administer enough of all, to keep the physiological process as near normal as possible while the patient is going through the disease. It is well to give an abundance of water to drink.

As to baths, the tepid friction bath is more agreeably borne by the patient and good reaction is usually secured; the ice cold bath has about been discarded. Cleansing baths are given daily. Occasional use of the ice-coil to head and abdomen keeps the patient quiet and comfortable and tends to keep down the fire. When a patient reacts well from a bath it is the proper one for him. By reaction is meant, the effect on the circulatory, respiratory and nervous system.

Salt solution enemas are given as a routine, three times in twenty-four hours if the temperature remains high. It lessens the toxemia, increases the

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